

11238

CERTIFICATE OF DEATH

11214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>8 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ALEXANDER NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>J HARRY BARNES</u>				4. DATE OF DEATH Month Day Year <u>OCT 26 1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 18 - 1874</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN W BARNES</u>				14. MOTHER'S MAIDEN NAME <u>MARY SIMPSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-10-5404</u>			
17. INFORMANT <u>BLAIR SIMPSON</u>				Address <u>MD UNION BRIDGE RURAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> <u>422.1</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/18/60</u> , 19 <u>60</u> , to <u>10/26/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/24/60</u> , 19 <u>60</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D.				ADDRESS (Street, city or town, state) <u>New Windsor, Md</u> DATE SIGNED <u>10/26/60</u>			
PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>				LOCATION (City, town, or county) (State) <u>NEW WINDSOR MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 29-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>UNION TOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DR Hartzler & Sons, Union Bridge Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11238

CERTIFICATE OF DEATH

1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

11239

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11215

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6yrs. 9mos. 29days Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 340 S. Bouldin St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Agnes Middle Beitz Last Beitz		4. DATE OF DEATH Month October Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1880
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR: Months 80 Days 80 Hours 80 Min. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany ✓	
13. FATHER'S NAME William Beitz		14. MOTHER'S MAIDEN NAME Amelia Beitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and arteriosclerotic cardiovascular disease. DUE TO (c) reaction.			
INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonitis. -C.B.S. assoc. with senile brain disease with psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 21, 1960 to Oct. 9, 1960 , that (I) (we) last saw the deceased alive on October 9, 1960 and that death occurred 10:30PM from the causes and on the date stated above.			
22a. SIGNATURE J. Raymond Gladue		22b. DATE SIGNED 10/10/60	
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-11-60	
23c. NAME OF CEMETERY OR CREMATORY St. Paul Fifth Reformed		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR OCT 13 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11240

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11216

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Eldersburg		c. LENGTH OF STAY IN 1b 7 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.O. Sykesville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle S. Last BENNETT		4. DATE OF DEATH Month Oct Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 70 Hours 40 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder contractor		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John R. Bennett		14. MOTHER'S MAIDEN NAME Elizabeth Shipley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. I 219-01-1678	
17. INFORMANT Mrs. Mary Bennett		Address Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung, Central metastases, 163X DUE TO (b) left hemiplegia, Cardiac failure, DUE TO (c) bronchial pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 1959 19 4 Oct 19 60 , that (I) (we) last saw the deceased alive on 4 Oct 19 60 , and that death occurred at 2 P.M. from the causes and on the date stated above. 22a. SIGNATURE Howard E. Hall M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4 Oct 60 22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M. D. 22d. ADDRESS Sykesville, Md			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 10-7-1960	
23c. NAME OF CEMETERY OR CREMATORY Taylorville Cemetery		23d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz		ADDRESS Winfield, Md.	
25a. REC'D BY REGISTRAR DATE OCT 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11217

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Gladys Last Stem		4. DATE OF DEATH Month October Day 23 , Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 00 Days 00 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey W. Stem		14. MOTHER'S MAIDEN NAME Lilly Engleman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-01-1206	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Congestive failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depressive reaction, manic type.			
INTERVAL BETWEEN ONSET AND DEATH 3 days. 1 year			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 1, 1960 to October 23, 1960 , that (I) (we) last saw the deceased alive on October 22, 1960 , and that death occurred at 1:50 AM , from the causes and on the date stated above.			
22a. SIGNATURE J. Raymond Gladue J. Raymond Gladue, M.D.		22b. DATE SIGNED 10/24/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct 23 1960		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		23d. LOCATION (City, town, or county) (State) 1300 Moreland Ave. Balto Md	
24. FUNERAL DIRECTOR'S SIGNATURE Lee M Cook		25a. REC'D BY REGISTRAR OCT 31 '60	
ADDRESS 1701 Patterson Rd		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. Name of the plant: *...*

2. Name of the collector: *...*

3. Locality: *...*

4. Date of collection: *...*

5. Number of specimens: *...*

6. Description of the plant: *...*

7. Remarks: *...*

8. Name of the collector: *...*

9. Name of the collector: *...*

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100. Name of the collector: *...*

CERTIFICATE OF DEATH

Reg. Dist. No. 11218

11234

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>25 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md.</u>		d. STREET ADDRESS <u>39 Webster St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>39 Webster St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROY</u> First <u>ERVIN</u> Middle <u>BOHN</u> Last		4. DATE OF DEATH Month <u>OCT.</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27 1905</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>19</u> Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Industrial</u>	
11. BIRTHPLACE (State or foreign country) <u>Detroit, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ervin Bohn</u>		14. MOTHER'S MAIDEN NAME <u>Ada Bitch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>216-09-3662</u>	
17. INFORMANT <u>Mrs. Roy Ervin Bohn, Same address</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma was found during an operation for hiatal hernia</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Feb. 15</u> , 19 <u>60</u> , to <u>Oct. 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct. 5</u> , 19 <u>60</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>10-6-60</u>			
ACTUAL SIGNATURE <u>C. H. Billingslea</u> M.D.		DATE SIGNED <u>10-6-60</u>	
PHYSICIAN'S NAME (Type) <u>C. H. Billingslea</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/8/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rural Westminster Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11234

CERTIFICATE OF DEATH

11234

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.

VR A15 (4)
15M 9/59

11242

11219

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN IL 2 years. 6 mos. 27 days. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 d. STREET ADDRESS 5 Orkney Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle Musser Last Bullock		4. DATE OF DEATH Month 10 Day 14 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Pennsylvania
13. FATHER'S NAME William H. Musser		14. MOTHER'S MAIDEN NAME Sarah E. Shiffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 17, 1958 , to October 14, 1960 , that (I) (we) last saw the deceased alive on October 14, 1960 , and that death occurred at 2P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. Raymond Gladue M.D.		22b. DATE SIGNED October 14, 1960	
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 10-15-60	
23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town, or county) (State) Belle Fonte, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. C. ok, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR DATE OCT 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Thoms			

11919

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11220

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31			
c. LENGTH OF STAY IN 1b 50 years				d. STREET ADDRESS 421 Durham St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle C. Last Bulter				4. DATE OF DEATH Month October Day 11 Year 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1880	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY Hair Cutting		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frederick C. Bulter				14. MOTHER'S MAIDEN NAME Elizabeth Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield State Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas with biliary obstruction DUE TO Candidations, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 157X DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dementia Praecox, hebephrenic type				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/16/10 19 60 , to 10/11 19 60 , that (I) (we) last saw the deceased alive on 10/11 19 60 , and that death occurred at 8 P M, from the causes and on the date stated above.							
22a. SIGNATURE Irene E. Hitchman, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/11/60	
22c. PHYSICIAN'S NAME (Type) Irene Hitchman, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-14-60		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight				ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 '60	
				25b. REGISTRAR'S SIGNATURE Arthur E. Haight			

03311

CENTRAL AIRCRAFT

413-13



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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11244
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11221
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS White's Ferry	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Rosa May Cubitt Butler		4. DATE OF DEATH Month Day Year October 5, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1882
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Cubitt		14. MOTHER'S MAIDEN NAME Christine Monred	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Severe anemia secondary to bleeding esophageal ulcer DUE TO (c) Arteriosclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 12, 1959 to October 5, 1960 , that (I) (we) last saw the deceased alive on October 5, 1960 , and that death occurred all:50PM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE 10/6/60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct 8-60		23b. DATE THEREOF Monocacy	
23c. NAME OF CEMETERY OR CREMATORY Beallsville		23d. LOCATION (City, town, or county) (State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Beallsville, Md		25a. REC'D BY REGISTRAR OCT 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11245

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11222

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Dykeville</i>		c. LENGTH OF STAY IN 1b <i>15 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CHARLES W. CAUTHORN</i>		4. DATE OF DEATH <i>Oct. 22 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 13, 1873</i>
9. AGE (In years last birthday) <i>87</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Harmon</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Learson Cauthorn</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Wayman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>M. A. Cauthorn - Dykeville, md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis, arteriosclerotic heart disease, cardiac failure.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>-</i> (c) DUE TO <i>-</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1959 to 22 Oct 60</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> 19 to <i>22 Oct</i> 1960, that (I) (we) last saw the deceased alive on <i>22 Oct</i> 1960, and that death occurred on <i>22 Oct</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard E. Hall</i>		22b. DATE SIGNED <i>23 Oct 60</i>	
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		22d. ADDRESS <i>Greenville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10-24-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Harmony</i>		23d. LOCATION (City, town, or county) (State) <i>Cooksville, Howard Co., Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Haight</i>		24a. ADDRESS <i>Dykeville, Md.</i>	
25a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE <i>OCT 26 '60</i>			

11583

CERTIFICATE OF DEATH

11583

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CHICAGO, ILL.

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TO THE CHIEF OF POLICE
CITY OF CHICAGO
FROM THE CHIEF OF POLICE
CITY OF CHICAGO
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a formal communication or report.]

Very truly yours,
[Illegible Signature]
[Illegible Title]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 11, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Woodbine MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Carroll City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Golden Age Guest Home		d. STREET ADDRESS 322 S. Gilmore Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRIETT Middle ELTON Last ELTON		4. DATE OF DEATH Month Oct 17 Day 1960 Year 19	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 3, 1860
9. AGE (In years last birthday) 100 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Balto Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Bessie Price 322 S. Gilmore St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO Heart Failure (c) Stroke PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart Failure INTERVAL BETWEEN ONSET AND DEATH 3 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1960 to Oct 17, 1960 , that (I) (we) last saw the deceased alive on Oct 15, 1960 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE MORRELL N. MASTIN		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) MORRELL N. MASTIN		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10.20.60	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Balto Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Mc. Cully 130 E Fort Ave Balto 30, Md.		25a. REC'D BY REGISTRAR Oct 20 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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CENTRIC AIR LINE

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1. PLACE OF DEATH o. COUNTY <i>Carroll</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i>		b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Airy</i>		c. LENGTH OF STAY IN 1b <i>60</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Airy</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>308 Park Ave.</i>				d. STREET ADDRESS <i>308 Park Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Annie</i> Middle <i>Brandenburg</i> Last <i>Eitchison</i>				4. DATE OF DEATH Month <i>October</i> Day <i>16</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 11, 1878</i>	
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William Brandenburg</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Mullinix</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>Mrs. Leola Beall. Mt. Airy, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>several years</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <i>19</i> Day <i>14</i> Year <i>1960</i> Hour <i>o. m.</i> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>October 1960</i> to <i>October 1960</i> , that (I) (we) last saw the deceased alive on <i>Oct. 14</i> 1960 and that death occurred at <i>5A</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>W.B. Culwell</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <i>W.B. Culwell</i>		22b. DATE SIGNED <i>10/16/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>W.B. Culwell</i>				22d. ADDRESS <i>Mount Airy, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 18, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Pine Grove</i>		23d. LOCATION (City, town, or county) (State) <i>Mt. Airy, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Olin L. Mohrwith</i>				ADDRESS <i>Damascus, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 20 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kins</i>			

11382

CERTIFICATE OF DEATH

11382

(M)

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11248
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11226

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 747 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 18X-2	
3. NAME OF DECEASED (Type or print) First James Middle Arthur Last Forbes		4. DATE OF DEATH Month October Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-4-1900
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Croome, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Forbes		14. MOTHER'S MAIDEN NAME Susie Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-3989	
17. INFORMANT James A. Forbes - patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced pulmonary tuberculosis, left. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 30, 1958 to Oct. 24, 1960 , that (I) (we) last saw the deceased alive on Oct. 24, 1960 , and that death occurred at 7:30 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Edgars M. Maculans		22b. DATE SIGNED 10-24-60	
22c. PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.		22d. ADDRESS Henryton State Hospital, Henryton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-24-60		23b. DATE THEREOF Woodlawn	
23c. NAME OF CEMETERY OR CREMATORY West, D.C.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Rollins		25a. REC'D BY REGISTRAR 4339 Hunt Pl NE	
25b. REGISTRAR'S SIGNATURE Wash. 19DC.		DATE OCT 26 '60	

11230

CERTIFICATE OF DEATH

11230

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CERTIFICATE OF DEATH

11227
Reg. Dist. No.

11249

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> X			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster 20 yrs.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster RD #2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pleasant Valley RD #2</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>HAZEL FRANCES GILBERT</i>				4. DATE OF DEATH <i>Oct. 14 1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 20, 1894</i>		9. AGE (In years last birthday) <i>66</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>River Falls, Wisconsin</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Clifton Wrenchell</i>			
14. MOTHER'S MAIDEN NAME <i>Mary Campbell</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>			
16. SOCIAL SECURITY NO. <i>—</i>				17. INFORMANT <i>Mr. Arthur C. Gilbert</i> Address <i>Same address</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary & Circulatory Metastasis</i> <i>153.9</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>adenocarcinoma; intestinal</i> DUE TO (c) <i>—</i>							INTERVAL BETWEEN ONSET AND DEATH <i>6 MONTHS</i> <i>10 MONTHS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June</i> , 19 <i>60</i> , to <i>October</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>October 12</i> , 19 <i>60</i> , and that death occurred at <i>8:29</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Daniel I. Welliver</i> M.D.				ADDRESS (Street, city or town, state) <i>19 RIDGE ROAD</i> DATE SIGNED <i>10-14-60</i>			
PHYSICIAN'S NAME (Type) <i>DANIEL I. WELLIVER WESTMINSTER MARYLAND</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 17, 60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Winters Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Rural New Windsor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr., Westminster, Md.</i> ADDRESS <i>—</i>				24a. REC'D BY REGISTRAR DATE <i>OCT 19 '60</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTRAL ASIAN

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[Faint, mostly illegible handwritten text on lined paper]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11250

11228

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> - T - Middle <u>HARE</u> Last				4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 6 - 1887</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>W. S. A.</u>	
13. FATHER'S NAME <u>John T Hare</u>				14. MOTHER'S MAIDEN NAME <u>Martha Bueblitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-496</u>		17. INFORMANT Address <u>Mrs James Hare - Hampstead, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Coronary Atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>3 yrs</u> <u>Unk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 1957, to <u>October 24</u> 1960, that (I) (we) last saw the deceased alive on <u>Oct. 20</u> 1960, and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>M. C. Porterfield</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M. C. Porterfield</u>				22d. ADDRESS <u>Hampstead, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Oct 27/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grave Run</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Lipton - Hampstead Md</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	
				DATE <u>OCT 26 '60</u>			

1158

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315

CENTRAL OFFICE OF RECORDS

1158

1158

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11251
11229
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH
Item 1 Film C274 11-7-60 et

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 Mos. 24 Dys.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Dressel Last Haynes		4. DATE OF DEATH Month Oct. Day 30 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 24, 1875
9. AGE (In years lost birthday) yrs. 84		10. IF UNDER 1 YEAR Months 84 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Female HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) Maryland, BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Dressel		14. MOTHER'S MAIDEN NAME Margaret	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic depressive reaction.		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8 - 6 1960 to 10 - 30 1960 , that (I) (we) last saw the deceased alive on 10 - 30 1960 , and that death occurred at 6:00 AM , from the causes and on the date stated above.			
22a. SIGNATURE J. Raymond Gladue M.D.		22b. DATE SIGNED 10 - 30 - 60	
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/2/60	
23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTO. MD.		25a. REC'D BY REGISTRAR DATE NOV 1 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

7. *Chlorophyll a*

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 11231
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 11230

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester R.D.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>A</u> Middle <u>HERSH</u> Last		4. DATE OF DEATH <u>October 4</u> Month <u>1960</u> Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-1877</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Kreitzer</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Hahner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>John Hersh-Manchester R.D.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anteroseptal Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate course (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collard Goitre (Thyroid) with tracheal compression</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1954</u> to <u>Oct 4</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Oct 3</u> 19 <u>60</u> , and that death occurred on <u>5:45 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W H Foard</u>		22b. DATE SIGNED <u>10-6-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>W H Foard M.D.</u>		22d. ADDRESS <u>Manchester, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct 7-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>	23d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C Nipton-Hampstead Md</u> ADDRESS		25a. REC'D BY REGISTRAR DATE <u>OCT 7 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

11231

CENTRAL AIR OF DEATH

11231

1

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1

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Handwritten notes in the lower section, including "11231" and "CENTRAL AIR OF DEATH".

Handwritten notes at the bottom of the page, including "11231" and "CENTRAL AIR OF DEATH".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

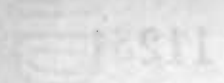
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11231

11252 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		2. USUAL RESIDENCE (where decedent lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 30	
c. LENGTH OF STAY IN 1b 4 moths. 9 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3001-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS 3123 Fleet St Balto.24	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Hoesch Last Hoesch		4. DATE OF DEATH Month 10 - Day 8 - Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-75
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months 8 Days 10 Hours 10 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hoesch		14. MOTHER'S MAIDEN NAME Margaret Schmidt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital records	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic brain syndrome associated with senile brain disease DUE TO (c) Chronic brain syndrome associated with senile brain disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease			
INTERVAL BETWEEN ONSET AND DEATH years years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-29 - 1960 , to 10-8 - 1960 , that (I) (we) last saw the deceased alive on 10 - 8 - 1960 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo.		22b. DATE 10-9-60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Sykesville, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-12-1960	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.		25a. REC'D BY REGISTRAR 11-11-60	
ADDRESS 1901 Eastern Avenue		25b. REGISTRAR'S SIGNATURE Charles S. Frame	



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11253

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg				c. LENGTH OF STAY IN 1b 25 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedarhurst Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Stephen Jones				4. DATE OF DEATH Month Day Year October 18 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-1874	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas S. Jones				14. MOTHER'S MAIDEN NAME Angeline Seller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Herman S. Jones		Address Finksburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Squamous cell carcinoma lower lip							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 48 Main Street	(County) Carroll	(State) Md.	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from 7-20- 19 60 to 10-18 19 60 , that I last saw the deceased alive on 10-13 - 19 60 , and that death occurred at 8:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown, Maryland DATE SIGNED 10-18-60							
ACTUAL SIGNATURE Martin E. Strobel		M.D. 48 Main Street		DATE SIGNED 10-18-60			
PHYSICIAN'S NAME (Type) Martin E. Strobel M.D.		Reisterstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-21-60	22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Smallwood, Carroll Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr.		ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE OCT 21 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FESTIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR ATS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11254

11233

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co. 03	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 days, 12 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sadie Middle Kanzler Last Kanzler		4. DATE OF DEATH Month Oct. Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-72
9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert McElwee		14. MOTHER'S MAIDEN NAME Jennie Jordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 420.1 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome due to arteriosclerosis cerebral and general-ized. INTERVAL BETWEEN ONSET AND DEATH years years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-4 - 1960 to 10-9 - 1960 , that (I) (we) last saw the deceased alive on 10-9 - 1960 , and that death occurred at 3:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE 10-8-60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo. M.D.		22d. ADDRESS Sykesville, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-12-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		25. REC'D BY REGISTRAR OCT 13 '60	
ADDRESS 5305 Harford Rd.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

11524

CERTIFICATE OF DEATH

11523



Official

days, 72 hours

Illinois State Hospital

Chicago

Death

Illinois

Illinois

Illinois

Illinois State Hospital

Illinois State Hospital

Illinois State Hospital

Illinois State Hospital

Illinois State Hospital

1

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b.p.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11255

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11234

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md.		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cooksville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sykesville				d. STREET ADDRESS Cooksville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle P. H. Last Kelley				4. DATE OF DEATH Month October Day 3, Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1908	
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Springfield State Hospital				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James B. Kelley				14. MOTHER'S MAIDEN NAME Bertha Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 155-12-6150		17. INFORMANT Mrs. H. H. Kelley (Wife) Address Cooksville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) EMBOLISM of CORONARY ARTERY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 hour							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10.3.60 to 10.3.60 , that (I) (we) last saw the deceased alive on 10.3.60 , and that death occurred at 10.40AM from the causes and on the date stated above.							
22a. SIGNATURE Wm. H. Lawson, Jr., M.D.				22b. DATE SIGNED 10.3.60			
22c. PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.				22d. ADDRESS Sykesville-2, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-5-1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dickey				25a. REC'D BY REGISTRAR Frederick, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE OCT 7 '60							

1133

CERTIFICATE OF DEATH

1133

General Hospital, New York City

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

John Doe, 45 years old

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster #2</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Rt 2</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Arnellus Grumme</i> First Middle Last		4. DATE OF DEATH <i>October 26</i> Month Day Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/18/1874</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired 1945 Grumme</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Carroll Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jacob Grumme</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Sheaffer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Albert Pepper Westminster Md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Haemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerosis</i> DUE TO <i>High Blood Pressure - Diabetes</i> (c) <i>High Blood Pressure - Diabetes</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 Mo.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Apr.</i> 19 <i>60</i> to <i>10/26/60</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>10/26</i> 19 <i>60</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Hancock Pa</i> DATE SIGNED <i>10/27/60</i> ACTUAL SIGNATURE <i>George P. Ard</i> M.D. <i>Hancock Pa</i> PHYSICIAN'S NAME (Type) <i>George P. Ard</i> <i>Hancock Pa</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>10/29/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Bartholomew's</i>	22d. LOCATION (City, town, or county) (State) <i>Hancock Pa York Co</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Fredrick Bucher Hancock Pa</i> ADDRESS		24a. REC'D BY REGISTRAR <i>OCT 31 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hanna</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11236

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 9yrs. 1mo. 6days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 5506 Morello Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Elizabeth Last Kummer		4. DATE OF DEATH Month October Day 25 , Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1919
9. AGE (In years lost birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 41 Days 16 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesgirl		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A. Kummer		14. MOTHER'S MAIDEN NAME Nettie Bickel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 491X DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type.			
INTERVAL BETWEEN ONSET AND DEATH weeks			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 14, 1960 to October 25, 1960 , that (I) (we) last saw the deceased alive on October 25, 1960 and that death occurred at 10:30 AM from the causes and on the date stated above.			
22a. SIGNATURE J. Raymond Gladue		22b. DATE SIGNED 10/25/60	
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1960/10/29/60		23b. DATE THEREOF 10/29/60	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem Cem		23d. LOCATION (City, town, or county) (State) Finksburg Md	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Rook		25a. REC'D BY REGISTRAR OCT 27 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Fraw			

11520

STATE OF TEXAS

11521



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11258

11257

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Evelyn Elizabeth Lawrence</u>			4. DATE OF DEATH Month Day Year <u>October 10 1960</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>June 22, 1912</u>		9. AGE (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Herbert Eyler</u>			14. MOTHER'S MAIDEN NAME <u>Lottie Heffner</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Wilbur Lawrence, Taneytown, Md. R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Papillary Adenocarcinoma of Ovaries</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>4/6</u> <u>1960</u> <u>10/10</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>10/9</u> <u>1960</u> , and that death occurred <u>10/10</u> <u>1960</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>R. S. McVaugh</u>				22b. DATE SIGNED <u>10/10/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>				22d. ADDRESS <u>Taneytown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/12/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baust Cemetery</u>			
23d. LOCATION (City, town, or county) _____ (State) _____		24. FUNERAL DIRECTOR'S SIGNATURE <u>C. O. Fuss & Son</u>					
25a. REC'D BY REGISTRAR DATE <u>OCT 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11523

CERTIFICATE OF DEATH

11523

10

U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11238
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLAUDE - E - LEIGHT</u>		4. DATE OF DEATH Month Day Year <u>Oct 30 - 19 60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Mln.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Leight</u>	
14. MOTHER'S MAIDEN NAME <u>Delia F. Foeble</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-10-717</u>		17. INFORMANT <u>Mrs. Homer Snyder</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auto Accident</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian - struck by automobile</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hampstead</u>	20f. (City or town) (County) (State) <u>Hampstead Carroll Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James T. Marsh</u>		DATE SIGNED <u>10/30/60</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emory Meth.</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll to Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edce Clifton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11250

11250

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF EXAMINER</p>	
<p>11. SIGNATURE OF WITNESS</p>		<p>12. SIGNATURE OF CORONER</p>	
<p>13. SIGNATURE OF JURY</p>		<p>14. SIGNATURE OF JUDGE</p>	
<p>15. SIGNATURE OF CLERK</p>		<p>16. SIGNATURE OF REGISTRAR</p>	
<p>17. SIGNATURE OF CHIEF OF POLICE</p>		<p>18. SIGNATURE OF SHERIFF</p>	
<p>19. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>20. SIGNATURE OF ATTORNEY GENERAL</p>	
<p>21. SIGNATURE OF COMMISSIONER OF HEALTH</p>		<p>22. SIGNATURE OF GOVERNOR</p>	
<p>23. SIGNATURE OF SENATE</p>		<p>24. SIGNATURE OF HOUSE OF REPRESENTATIVES</p>	
<p>25. SIGNATURE OF JUDICIAL BRANCH</p>		<p>26. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>27. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>28. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>29. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>30. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>31. SIGNATURE OF JUDICIAL BRANCH</p>		<p>32. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>33. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>34. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>35. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>36. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>37. SIGNATURE OF JUDICIAL BRANCH</p>		<p>38. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>39. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>40. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>41. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>42. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>43. SIGNATURE OF JUDICIAL BRANCH</p>		<p>44. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>45. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>46. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>47. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>48. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>49. SIGNATURE OF JUDICIAL BRANCH</p>		<p>50. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>51. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>52. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>53. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>54. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>55. SIGNATURE OF JUDICIAL BRANCH</p>		<p>56. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>57. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>58. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>59. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>60. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>61. SIGNATURE OF JUDICIAL BRANCH</p>		<p>62. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>63. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>64. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>65. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>66. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>67. SIGNATURE OF JUDICIAL BRANCH</p>		<p>68. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>69. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>70. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>71. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>72. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>73. SIGNATURE OF JUDICIAL BRANCH</p>		<p>74. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>75. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>76. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>77. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>78. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>79. SIGNATURE OF JUDICIAL BRANCH</p>		<p>80. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>81. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>82. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>83. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>84. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>85. SIGNATURE OF JUDICIAL BRANCH</p>		<p>86. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>87. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>88. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>89. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>90. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>91. SIGNATURE OF JUDICIAL BRANCH</p>		<p>92. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>93. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>94. SIGNATURE OF JUDICIAL BRANCH</p>	
<p>95. SIGNATURE OF EXECUTIVE BRANCH</p>		<p>96. SIGNATURE OF LEGISLATIVE BRANCH</p>	
<p>97. SIGNATURE OF JUDICIAL BRANCH</p>		<p>98. SIGNATURE OF EXECUTIVE BRANCH</p>	
<p>99. SIGNATURE OF LEGISLATIVE BRANCH</p>		<p>100. SIGNATURE OF JUDICIAL BRANCH</p>	

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
11260

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11239

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
c. LENGTH OF STAY IN 1b 9 years				d. STREET ADDRESS 809 Violet Place,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Adam Last Lindner				4. DATE OF DEATH Month October Day 12 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/26/69	
9. AGE (In years lost birthday) 90 yrs.		IF UNDER 1 YEAR Months 2 Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Lindner				14. MOTHER'S MAIDEN NAME Emily Huldie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Springfield State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pancreatitis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis, paranoid with hypertension and generalized arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10/16 1960 to 10/12 1960 , that (I) (we) lost saw the deceased alive on 10/12 1960 , and that death occurred on 10/12 1960 from the causes and on the date stated above.							
22a. SIGNATURE Ellis S. Margolin				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/12/60	
22c. PHYSICIAN'S NAME (Type) Ellis S. Margolin, M.D.				22d. ADDRESS Springfield State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 4, 1960		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Charlotte Ralston				ADDRESS 254 Carroll St NW DC		25a. REC'D BY REGISTRAR DATE OCT 13 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11232

Items 1, 14, 27, 30-31-60 et

11240

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenmount, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) 19 Locust Street (home)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles HENRY Mahaley.				4. DATE OF DEATH Month Day Year October 11 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 10, 1879	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Canning Factory			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Mahaley.				14. MOTHER'S MAIDEN NAME Christina Kaugle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 216-09-0695			
17. INFORMANT Mrs Chas Mahaley				Address Manchester Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Primary Carcinoma Stomach							
151X DUE TO (b) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-Sclerotic Cardiovascular Disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from June 15 19 60 to Oct 11 19 60 , that (I) (we) last saw the deceased alive on Oct 11 19 60 , and that death occurred at 2:45 P M, from the causes and on the date stated above.							
22a. SIGNATURE Joseph E. Bush M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 10-11-66							
22c. PHYSICIAN'S NAME (Type) Joseph E. Bush MD 22d. ADDRESS Hampstead Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10-14-60			
23c. NAME OF CEMETERY OR CREMATORY Manchester				23d. LOCATION (City, town, or county) Carroll Co Md (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE Edw E Tipton				25a. REC'D BY REGISTRAR OCT 14 '60 DATE			
ADDRESS Hampstead Md				25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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11261
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11241

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3yrs.2mos.17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3001-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 307 Herring Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		First John		Middle Masijauskas		Last October 7, 1960	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1868	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Naturalized	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-14-2405		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction. Renal nephrosclerosis.		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 1 yr.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/14/60 19 to October 7, 1960 , that (I) (we) last saw the deceased alive on 10/7/60 19, and that death occurred at 1:30 PM from the causes and on the date stated above.							
22a. SIGNATURE J. Raymond Gladue		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 10/7/60			
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue		22d. ADDRESS Springfield Hospital, Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 10, 1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d. LOCATION (City, town, or county) (State) O'Donnell St. Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA				ADDRESS 7922 Wise Avenue 22, Md.		25a. REC'D BY REGISTRAR DATE OCT 11 '60	
				25b. REGISTRAR'S SIGNATURE Charles S. Kraw			

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1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 5 MOS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULLERTON		03X - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PULLEN NURSING HOME				d. STREET ADDRESS EAST JOPPA ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROSETTA MCDANIEL				4. DATE OF DEATH Month Day Year 10 9 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/4/1886	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) VIrginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES LESTER		14. MOTHER'S MAIDEN NAME RENT SIMMONS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 2-29-44-4002		17. INFORMANT POSEY L. MCDANIEL		Address 234 E JOPPA RD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, Arteriosclerotic heart disease DUE TO Arteriosclerosis, gangrene of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. left foot & legs. DUE TO (b) Arteriosclerosis, gangrene of DUE TO (c) left foot & legs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Frederick VIRGINIA		21. I certify that (I) (this hospital) attended the deceased from June 19 60 to 9 Oct 19 60 , that (I) (we) last saw the deceased alive on 9 Oct 19 60 and that death occurred at 7:30 PM , from the causes and on the date stated above.	
22a. SIGNATURE Harold E. Hall		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Harold E. Hall	
22d. ADDRESS Apexville, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 20, 1960		23c. NAME OF CEMETERY OR CREMATORY WHITE OAK GROVE	
23d. LOCATION (City, town, or county) (State) FREDERICK VIRGINIA		24. FUNERAL DIRECTOR'S SIGNATURE Sossah Funeral Home 7401 Belair Rd #6.		25a. REC'D BY REGISTRAR DATE OCT 14 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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CERTIFICATE OF DEATH

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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Woodbine			c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Woodbine					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. F. D. 1					d. STREET ADDRESS 1 R. F. D. 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET M. MILLER					4. DATE OF DEATH Month October Day 3 , Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 29, 1912		9. AGE (In years last birthday) yrs. 48		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY State Hosp.		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME J. Donald Miller					14. MOTHER'S MAIDEN NAME Mary C. Bloom					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----					16. SOCIAL SECURITY NO. 220-18-1360		17. INFORMANT Mrs. Mary C. Miller, Address Same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420-1 IMMEDIATE CAUSE (a) EMBOLISM OF CORONARY ARTERY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 min-								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1935 , 19, to 10/3 , 19 60 , that (I) (we) last saw the deceased alive on 10/3 , 19 60 , and that death occurred at 5:00 P. M., from the causes and on the date stated above.										
22a. SIGNATURE W. H. Lawson, Jr., M.D.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/3/60			
22c. PHYSICIAN'S NAME (Type) W. H. LAWSON, JR., M.D.					22d. ADDRESS SYKESVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 6, 1960		23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery			23d. LOCATION (City, town, or county) (State) Sykesville, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,					ADDRESS Winfield, Maryland		25a. REC'D BY REGISTRAR DATE OCT 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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VR A1S (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 30yrs. 1mo. 17days		d. STREET ADDRESS 1633 S. Charles St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Last Moren		4. DATE OF DEATH Month October Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1905
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Timothy J. Moran		14. MOTHER'S MAIDEN NAME Katherine Imhoff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type.		INTERVAL BETWEEN ONSET AND DEATH Months
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/27/55 19 55 to October 19, 1960 , that (I) (we) lost saw the deceased alive on October 18 1960 , and that death occurred at 7:55AM from the causes and on the date stated above.			
22a. SIGNATURE <i>Julian Radcykowycz</i>		22b. DATE SIGNED 10/19/60	
22c. PHYSICIAN'S NAME (Type) Julian Radcykowycz, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Maryland	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/22/60	23c. NAME OF CEMETERY OR CREMATORY Holy Cross	23d. LOCATION (City, town, or county) (State) Reschie Highway
24. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Salustiano</i>		25. REC'D BY REGISTRAR OCT 21 '60	
ADDRESS 1318 Light		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

11264

DEPARTMENT OF HEALTH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11265 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11245									
1. PLACE OF DEATH e. COUNTY Carroll					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Carroll				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville					c. LENGTH OF STAY IN 1b 9 years				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sykesville					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville				
3. NAME OF DECEASED (Type or print) Charles Summers PICKETT					4. DATE OF DEATH Month Oct. Day 30, Year 1960				
5. SEX male		6. COLOR OR RACE wh		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1903		9. AGE (In years birth day) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME Edward Summer Pickett					14. MOTHER'S MAIDEN NAME Olevia Davis				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-01-9844		17. INFORMANT Address Mrs. Elizabeth M. Pickett, Same as 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Near-contact gunshot wound of head DUE TO 919.0 Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found shot in head						
20c. TIME OF INJURY Month, Day, Year 6:45 a.m. 10/30/60			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Sykesville		(County) Carroll (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> W. Bradley King, Jr. ACTUAL SIGNATURE EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 10/30/60 DATE SIGNED									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Morgan Chapel Cemetery			22d. LOCATION (City, town, or country) (State) Carroll Co. Maryland		
23. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Winfield, Maryland					24a. REC'D BY REGISTRAR DATE NOV 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns		

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June 1, 1903

Clerks Davis

117-01-9810 Mrs. Elizabeth A. Brown

Not-returned names as in above

Only in 1900

10/30/00

Nov. 1900 Morgan Chase-Campsey Carroll Co. Maryland

C. M. White, Winfield, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11266												11246											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH												CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND												2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville						c. LENGTH OF STAY IN 1b 26 Days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital												d. STREET ADDRESS 6912 Woodside Place											
3. NAME OF DECEASED (Type or print) First Allen Middle Hussell Last Potts												4. DATE OF DEATH Month 10 Day 15 Year 1960											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 5, 1888				9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months 10 Days 15		IF UNDER 24 HRS. Hours 15 Min. 1960									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architecture				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Peter Wilson Potts						14. MOTHER'S MAIDEN NAME Mary Elizabeth Kellough																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -				17. INFORMANT Springfield Hospital Records				Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 463X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary embolism DUE TO (c) Thrombophlebitis left leg.												INTERVAL BETWEEN ONSET AND DEATH days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 9/19/60 19 to 10/15/60 19, that (I) (we) last saw the deceased alive on 10/15/60 19, and that death occurred at 8:45 a.m. from the causes and on the date stated above.																							
22a. SIGNATURE Agustin del Campo M.D.												22b. DATE 10/15/60											
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.												22d. ADDRESS Springfield Hospital, Sykesville, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 10/17/60				23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				23d. LOCATION (City, town, or county) (State) Baltimore, Md.											
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co												25a. REC'D BY REGISTRAR OCT 18 '60											
ADDRESS 2901 14th St. N.W. Washington 9, D.C.												25b. REGISTRAR'S SIGNATURE Arthur S. Hines											

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11247

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 4,453 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Douglas Middle Preston Last Preston				4. DATE OF DEATH Month October Day 18 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27, 1913	9. AGE (In years lost birthday) 47 yrs.	IF UNDER 1 YEAR Months 47 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plate Grinder			10b. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Appomattox, Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Stephen Preston				14. MOTHER'S MAIDEN NAME Josephine Hunter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 718-12-9444		17. INFORMANT Douglas Preston - Patient			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far adv. bilateral cavitory pulmonary tbc. DUE TO (c) 12 years							INTERVAL BETWEEN ONSET AND DEATH 12 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 9, 1948 to Oct. 18, 1960 that (I) (we) lost the deceased alive on Oct. 18, 1960 , and that death occurred at 2:30 a.m. from the causes and on the date stated above.							
22a. SIGNATURE <i>Edgars M. Maculans</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-18-60	
22c. PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.				22d. ADDRESS Henryton State Hospital, Henryton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 10/22/60		23b. DATE THEREOF 10/22/60		23c. NAME OF CEMETERY OR CREMATORY WALLE Baptist Cem.		23d. LOCATION (City, town, or county) (State) Appomattox Co. VA	
24. FUNERAL DIRECTOR'S SIGNATURE West Funeral Home Appomattox VA				25a. REC'D BY REGISTRAR OCT 24 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11268

11248

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Burrill</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Burrill</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers, Rural</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers - Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>IRVING</u> Last <u>RAILSBACK</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 4 - 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeremiah Railsback</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Bastie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs Pearl McElrath: Hagerstown Md. P.O.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James J. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES J. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-27-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cleveland D. Tipton - Hagerstown Md</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kress</u>	

DATE SIGNED

10/26/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 306 W. Chapline St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Della Middle May Last Drenner		4. DATE OF DEATH Month October Day 30 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas Drenner		14. MOTHER'S MAIDEN NAME Mary Jane Domer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute suppurative nephritis 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral bronchopneumonia. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week. 1 week.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 30, 1960 to 10/30/60 , that (I) (we) last saw the deceased alive on 10/30/60 , and that death occurred at 2:25 PM from the causes and on the date stated above.			
22a. SIGNATURE J. Raymond Gladue		22b. DATE SIGNED 10/31/60	
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Leaf Funeral Home, Williamsport, Md.		25a. REC'D BY REGISTRAR DATE NOV 2 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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CHIEF OF DEPT.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11270

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11250

1. PLACE OF DEATH COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b ly. 3m. 15d.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fannie Middle Hobby Last Richmond		4. DATE OF DEATH Month 10 Day 3 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/1869
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 10 Days 3 Hours 19 Min.	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Swan		14. MOTHER'S MAIDEN NAME Minerva Reynolds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Springfield Hospital records, Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH hours years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with senile brain disease with psychosis.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/18 1960 , to 10/3 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/3 1960 , and that death occurred at 8:55 PM , from the causes and on the date stated above.			
22a. SIGNATURE Rita S. Glahn		22b. DATE 10/4/60	
22c. PHYSICIAN'S NAME (Type) Rita S. Glahn, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 6, 1960	
23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION (City, town, or county) (State) Prince George's County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St. N.W. D.C.		25. REC'D BY REGISTRAR Oct 6 1960	
25a. ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Glahn	

11520

CERTIFICATE OF DEATH

11520

1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11271

11251

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5mos. 11days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Last Riess				4. DATE OF DEATH Month October Day 13 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1887	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? Naturalized	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender				10b. KIND OF BUSINESS OR INDUSTRY Germany			
13. FATHER'S NAME Jacob Riess				14. MOTHER'S MAIDEN NAME Anna - Schmidt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-30-3247		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) 490X (c) Pre-senile psychosis.							INTERVAL BETWEEN ONSET AND DEATH 5 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Pre-senile psychosis.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 15, 1960 to Oct. 13, 1960 , that (I) (we) last saw the deceased alive on Oct. 13, 1960 and that death occurred at 11PM , from the causes and on the date stated above.							
22a. SIGNATURE J. Raymond Gladue M.D.				22b. DATE 10/14/60			
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-1960		23c. NAME OF CEMETERY OR CREMATORY London Park Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				25a. REC'D BY REGISTRAR DATE OCT 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

BP

11231

CERTIFICATE OF DEATH

11231

Blank certificate form with faint lines and text, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through from the reverse side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11272

11252

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenmount</i>		c. LENGTH OF STAY IN 1b <i>5-yr</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>JOHN - FRANK - RINEHART</i>		4. DATE OF DEATH <i>Oct 29 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 6 - 1869</i>
9. AGE (In years last birthday) <i>91</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Laborer</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Rinehart</i>		14. MOTHER'S MAIDEN NAME <i>Maudella Herbst</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-24-7287</i>	
17. INFORMANT <i>Ms F.C. Gapeviki</i>		Address <i>4347 Shelden</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Benign Prostatic Hypertrophy</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1960</i> 19 <i>October 29</i> 19 <i>60</i> , that (I) (we) lost saw the deceased alive on <i>10-29</i> 19 <i>60</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>M.C. Porterfield</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>M.C. Porterfield</i>		22d. ADDRESS <i>Hampstead, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-1-1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Manchester</i>		23d. LOCATION (City, town, or county) (State) <i>Carroll Co Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Edw. E. Clifton</i>		25a. REC'D BY REGISTRAR <i>NOV 1 '60</i>	
ADDRESS <i>Hampstead Md</i>		25b. REGISTRAR'S SIGNATURE <i>Catharine L. Howard</i>	

11523

CERTIFICATE OF DEATH

11523

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

11. Name of informant: [illegible]
12. Address of informant: [illegible]
13. Signature of informant: [illegible]
14. Date of completion: [illegible]
15. Registrar's office: [illegible]

11273
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11253

1. PLACE OF DEATH o. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City J. STREET ADDRESS 19 Newcut Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Alexander Rogers				4. DATE OF DEATH Month Day Year October 1, 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-7-1908	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaper				10b. KIND OF BUSINESS OR INDUSTRY Granite, Md.		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Will Rogers				14. MOTHER'S MAIDEN NAME Ollie Hall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-24-3764		17. INFORMANT George A. Rogers - Patient			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cystic disease of both lungs and pneumonitis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 28, 1960 to Oct. 1, 1960 , that (I) (we) last saw the deceased alive on Oct. 1, 1960 , and that death occurred at 915 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Edgars M. Maculans, M.D.				22b. DATE SIGNED Oct. 1, 1960			
22c. PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.				22d. ADDRESS Henryton State Hospital, Henryton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Sept. 6, 60		23b. DATE THEREOF Sept. 6, 60		23c. NAME OF CEMETERY OR CREMATORY North Annapolis Beach		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Russell				25a. REC'D BY REGISTRAR Robert S. and		25b. REGISTRAR'S SIGNATURE Oct 13 '60	

11273

CENTRAL 1 ON DEATH

11253

1

CERTIFICATE OF DEATH

Reg. Dist. No.

11254

11235

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 4 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEWIS Middle HOWELL Last SCHNAUBLE		4. DATE OF DEATH Month OCTOBER Day 23 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 18 1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME CHRISTIAN F. M. SCHNAUBLE		14. MOTHER'S MAIDEN NAME LAURA CLEFFLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service: <input type="checkbox"/>		16. SOCIAL SECURITY NO. 220-12-5093	
17. INFORMANT MRS. GRACE SCHNAUBLE (WIFE)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.1 (c) 20 YEARS		INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 59 , to OCTOBER 1960 , that I last saw the deceased alive on OCTOBER 23, 1960 , and that death occurred at 9:43 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel I. Welliver M.D.		ADDRESS (Street, city or town, state) 19 RIDGE ROAD DATE SIGNED OCT 23 1960	
PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER		WESTMINSTER MARYLAND.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/26/60	
22c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT		22d. LOCATION (City, town, or county) (State) GAMBER, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Safford		ADDRESS Westminster	
24a. REC'D BY REGISTRAR OCT 25 60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11337

11337

1. NAME OF DECEASED JOHN J. WATSON		2. SEX MALE	
3. AGE 31		4. DATE OF BIRTH MAY 19 1907	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION LABORER	
7. CAUSE OF DEATH ARTERIAL DYSPLASIA		8. PLACE OF DEATH HOME	
9. DATE OF DEATH MAY 22 1938		10. TIME OF DEATH 10:00 AM	
11. SIGNATURE OF PHYSICIAN J. J. WATSON		12. SIGNATURE OF WITNESSES J. J. WATSON	
13. SIGNATURE OF REGISTRAR J. J. WATSON		14. SIGNATURE OF CLERK J. J. WATSON	

1

11236

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11255

Item 9 Film Q273 10-26-60 et

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>9 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>74 W. Green St.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>74 W. Green St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>SHIPLEY</u> Last <u>SHIPLEY</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Westminster Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Dr. Daniel G. Shipley</u>	
14. MOTHER'S MAIDEN NAME <u>Genevieve Lambert</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Paul Shipley, Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis Agitans</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 10 1949</u> to <u>Oct 19 1960</u> , that (I) (we) last saw the deceased alive on <u>Oct 19 1960</u> , and that death occurred at <u>7:51 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Julius Chepko</u>		22b. DATE SIGNED <u>10/20/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>		22d. ADDRESS <u>85 1/2 W. Green St. Westminster Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/24/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Westminster Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Ziegler, Jr.</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
25c. DATE <u>OCT 21 '60</u>			

11235

CERTIFICATE OF DEATH

11235

1

Postmaster General

Oct 10 1891

Oct 10 1891

Johns Hopkins

25 W. 2nd St. West

11274

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11256

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY City311 ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2235 Lamley St.	
3. NAME OF DECEASED (Type or print) First Homer Middle Last Slemp		4. DATE OF DEATH Month October Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 10, 1988
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patton Slemp		14. MOTHER'S MAIDEN NAME Martha Slemp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 401 01 1483	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Arteriosclerotic Heart Disease years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS-assoc. with circulatory disturbance-cerebral arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH minutes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-15- 1955 to 10-16 1960 , that (I) (we) lost 10-16 1960 , and that death occurred at 1 A M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Julian Radzykewycz</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, MD		22d. ADDRESS Springfield Hospital, Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-60	
23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. (14)		25a. REC'D BY REGISTRAR OCT 19 60	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>			

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11350

11350

MAINTAIN ALL INFORMATION OF HEALTH
AND ALL INFORMATION OF THE DEPARTMENT OF HEALTH
AND ALL INFORMATION OF THE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and other details. The text is mostly illegible due to blurring and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11275
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11257

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 7mos. 13days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		d. STREET ADDRESS 1236 E. Belvedere Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Alexander Last Smoot		4. DATE OF DEATH Month October Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1895 January 15, 1902
9. AGE (In years lost birthday) 65		10. IF UNDER 1 YEAR Months 5 Days 6 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer of storm		10b. KIND OF BUSINESS OR INDUSTRY windows -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gerard Smoot (Gerard Wood Crain Smoot)		14. MOTHER'S MAIDEN NAME Verlinda Brawner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1917 - 1942	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the larynx DUE TO 161X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 3, 1959 to October 16, 1960 , that (I) (we) last saw the deceased alive on October 16, 1960 , and that death occurred at 6:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 10/17/60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/19/60	
23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tickner & Sons - Balto		25a. REC'D BY REGISTRAR DATE OCT 18 '60	
ADDRESS 17 Md		25b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

1155

CENTRIFUGAL DE OXIDATION

1155



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11276

11258

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROOKFIELD MANOR N. H.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELLEN STALLINGS</u>		4. DATE OF DEATH Month Day Year <u>OCT. 7 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 MAR. 1875</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GERARD KREIMER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH EKING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-36-8696</u>	
17. INFORMANT <u>MRS GRAFTON BOONE</u>		Address <u>UNION BRIDGE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardio-vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>disease</u> DUE TO (c) <u>heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/7/58</u> , 19 <u>58</u> , to <u>10/7/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>10/7/60</u> , 19 <u>60</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Robertson</u>		ADDRESS (Street, city or town, state) <u>New Windsor, Md</u> DATE SIGNED <u>10/8/60</u>	
PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>		<u>NEW WINDSOR MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11 OCT 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEM</u>		22d. LOCATION (City, town, or county) (State) <u>UNION TOWN MD</u>	
22e. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Hartshorn</u>		ADDRESS <u>UNION BRIDGE MD.</u>	
24a. REC'D BY REGISTRAR <u>OCT 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

AT 2000045-100546 NORTH AND DATE 02/07/01



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11277

11259

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 10mos. 18days d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 1 3401.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 837 Hamilton Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Stanley Last Tucker		4. DATE OF DEATH Month October Day 1 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1882
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Tucker		14. MOTHER'S MAIDEN NAME Blanche Ada O'Hara	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 216-07-8024A	
17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491 X Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with alcohol intoxication with psychotic reaction. Arteriosclerotic cardiovascular disease.		INTERVAL BETWEEN ONSET AND DEATH 11 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/14/60 19 to 10/1/60 19, that (I) (we) last saw the deceased alive on 10/1/60 19, and that death occurred at 2:45 PM from the causes and on the date stated above.			
22a. SIGNATURE J. Raymond Gladue M.D.		22b. DATE SIGNED 10/2/60	
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/60	
23c. NAME OF CEMETERY OR CREMATORY All Hallows Cem.		23d. LOCATION (City, town, or county) (State) Birdsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Sicker ADDRESS 117 P. O. Box 19		25a. REC'D BY REGISTRAR DATE OCT 4 '60	
25b. REGISTRAR'S SIGNATURE Arthur d. Smith			

11277

11280

CERTIFICATE OF DEATH

State of New York

County of ...

City of ...

State of New York

County of ...

City of ...

County of ...

City of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11278

12034

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN lb 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
4. DATE OF DEATH (Type or print) Catherine Reaves Walker		5. DATE OF DEATH Month 10 Day 29 Year 1960	
6. SEX Female		7. COLOR OR RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH March 3, 1931	
10. AGE (In years lost birth day) 29 yrs.		11. IF UNDER 1 YEAR Months Days Hours Min.	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		13. KIND OF BUSINESS OR INDUSTRY Wilmington, N.C.	
14. BIRTHPLACE (State or foreign country) U. S. A.		15. CITIZEN OF WHAT COUNTRY? U. S. A.	
16. FATHER'S NAME James Ryams		17. MOTHER'S MAIDEN NAME Clara Reaves	
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		19. SOCIAL SECURITY NO. Catherine Walker	
20. INFORMATION Catherine Walker		21. ADDRESS	
22. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Insufficiency DUE TO Fibrosis of lungs, far advanced bilateral pulmonary tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Chronic alcoholism DUE TO Chronic alcoholism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
25. TIME OF INJURY Month, Day, Year Sept. 30, 1960 to Oct. 29, 1960			
26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Henryton State Hospital, Henryton, Md.			
28. (City or town) Baltimore, Md. (County) (State)			
29. I certify that (I) (this hospital) attended the deceased from Sept. 30, 1960 to Oct. 29, 1960 , that (I) (we) last saw the deceased alive on Oct. 29, 1960 , and that death occurred at 5:45P M, from the causes and on the date stated above.			
30. SIGNATURE Edgars M. Maculans M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 10-29-60			
31. PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D. 22d. ADDRESS Henryton State Hospital, Henryton, Md.			
32. BURIAL, CREMATION, REMOVAL (Specify) Mr. H - 60 33. NAME OF CEMETERY OR CREMATORY Panama Beach 34. LOCATION (City, town, or county) Baltimore, Md. (State)			
35. FUNERAL DIRECTOR'S SIGNATURE Frank H. Nunnally ADDRESS Baltimore, Md. 36. REC'D BY REGISTRAR NOV 7 '60 37. REGISTRAR'S SIGNATURE Arthur S. Kraus			

12001

CERTIFICATE OF DEATH

11278

Married

Carroll

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

No

Married

Married

Married

Married

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Married

Married

Married

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

1
11279
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11260

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 1 yr. 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Annie (Anna) Middle Williams Last Williams		4. DATE OF DEATH Month 10 Day 10 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/72
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 88 Days 10 Hours 10 Min. 19 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing house		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Weidinger		14. MOTHER'S MAIDEN NAME Cunegunde (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Springfield Hosp. records	
17. INFORMANT Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease (mitral & aortic insufficiency) DUE TO (c) Bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with senile brain disease without qualifying phrase in a congenital microcephalic mental defective.			
INTERVAL BETWEEN ONSET AND DEATH Years One day			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/24 19 59 to 10/10 19 60 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 10/10 19 60 , and that death occurred on 8:30 PM. from the causes and on the date stated above.			
22a. SIGNATURE Rita S. Glahn		22b. DATE 10/11/60	
22c. PHYSICIAN'S NAME (Type) Rita S. Glahn, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-13-60	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) 3310 Taylor Avenue	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR OCT 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

14
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Form Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
11261														
1. PLACE OF DEATH a. COUNTY <u>Carroll County</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>					c. LENGTH OF STAY IN 1b <u>YEARS</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6 COURT ST EXT</u>					d. STREET ADDRESS <u>WESTMINSTER 27</u>									
3. NAME OF DECEASED (Type or print) <u>Olean Vivian Woodward</u>					4. DATE OF DEATH <u>OCT 22 1960</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>COL</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 29 - 1918</u>		9. AGE (In years last birthday) <u>42</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WORK</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME <u>HOWARD JONES</u>					14. MOTHER'S MAIDEN NAME <u>ELIZABETH ADAMS</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <u>219-20-4786</u>					17. INFORMANT <u>HOWARD JONES</u> Address <u>NEW WINDSOR MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>98 IX Gunshot Wound of head</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____								
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Wm. V. Lovett</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>WM. V. LOVETT</u>					M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
					Address (Street, city, town, or county) <u>10/23/60</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 25 - 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT JOY</u>		22d. LOCATION (City, town, or country) <u>UNIONTOWN</u>		(State) <u>MD</u>						
23. FUNERAL DIRECTOR <u>DD Hartzler & Sons, New Windsor, Md</u>					24a. REC'D BY REGISTRAR <u>OCT 26 '60</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>				

11861

11861 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE

USE ONLY

1

1